ROBERT J. MARO, M.D., P.A.
Medical History Form

Name _____

Family or Referring Physician _____ Date of Last Physical Exam _____

Height _____ Weight _____ Blood Pressure _____

Reason for Today's Visit _____

Yes	No	
( )	( )	**Do you take any medications regularly? Please list: _____**
		_____
( )	( )	**Are you allergic to any drugs or medications? Please list: _____**
		_____
( )	( )	**Have you ever had any hospitalizations or surgeries? Please list including dates: _____**
		_____
( )	( )	**Have you ever had any serious injuries or accidents? Please list including dates: _____**
		_____
( )	( )	**Have you ever had any serious diseases or illness? Please list including dates: _____**
		_____
( )	( )	**Has anyone in your family ever had any serious disease or illness? Please list: _____**
		_____
		Are both of your parents alive? Yes or No? Mother _____ Father _____
		If deceased, please list disease or illness _____
		_____
( )	( )	**Women: Is there a chance that you are pregnant?**
Yes	**No**	***Do you have or have you ever had:***
( )	( )	**Problems with eyes, ears, nose or throat? _____**
( )	( )	**Thyroid or goiter problems? _____**
( )	( )	**Diabetes? _____**
( )	( )	**Does anyone in your family have diabetes mellitus? _____**
( )	( )	**Epilepsy or seizures? _____**
( )	( )	**High blood pressure? _____**
( )	( )	**Gout? _____**
( )	( )	**A stroke? _____**
( )	( )	**Heart disease or mitral valve prolapse? _____**
( )	( )	**Lung disease, asthma, emphysema, bronchitis, or shortness of breath? _____**
( )	( )	**Hepatitis, cirrhosis, or jaundice? _____**
( )	( )	**Any kidney or bladder problems? _____**
( )	( )	**Stomach ulcers, colon problems, or hernias? _____**
( )	( )	**Anemia or sickle cell disease? _____**
( )	( )	**Arthritis? _____**
( )	( )	**Muscle, bone, or joint disease? _____**
( )	( )	**Fractures? _____**
( )	( )	**Blood clots, phlebitis, or bleeding problems? _____**
( )	( )	**Rheumatic fever? _____**
( )	( )	**Do you drink alcoholic beverages? How much? _____? How often? _____**
( )	( )	**Do you or did you ever smoke? (please circle: Cigarettes, Pipe, Cigars)**
		Number of packs/day _____ How long? _____ years Date quit: _____
( )	( )	**Do you have any problems with circulation, movement, or sensations in your feet or legs? _____**
		_____
( )	( )	**Do you have any disease or condition not listed above? _____**

DATE_____ SIGNATURE _____

DATE_____ PHYSICIAN SIGNATURE_____